



State of Montana
Department of Corrections
Youth Services Division
Representative Payee Application

Fax to (406) 441-1065

Youth's Name: [youth's full name]

Youth's Social Security Number:

Youth's Date of Birth:

Date Youth Entered Care:

Placed at:

Name: [Facility's name]

Address: [address]
[city], [state] [zip code]

Phone: () -

Statement of Montana Department of Corrections

The Department of Corrections wishes to serve as payee for this youth, and we request the benefits be suspended until a new payee is selected.

Employee Signature: _____

Title: Regional Administrative Officer

Phone: (406) -

Date:

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